FAIRFAX COUNTY FIRE & RESCUE DEPARTMENT

(USE **PENCIL** FOR EASE IN MAKING CHANGES)

Date Form Completed/Updated:

Name:	Sex: M F
Address:	

Date of Birth:	Blood Type:
Language Spoken:	
Primary Doctor:	Phone #: ( )
Next of Kin:	Phone #: ( )

EMERGENCY CONTACTS

Name:	Phone #: ( )
Address:	
Name:	Phone #: ( )
Address:	

CURRENT MEDICAL DATA

Communicable Disease(s):

Do you have a DNR form? YES ❑ NO ❑

MEDICATIONS

Type	Dosage	Frequency:

MEDICAL CONDITIONS

(Check all that exist)

- ❑ No Known Medical Conditions
- ❑ Abnormal EKG/Dysrhythmias
- ❑ Angina
- ❑ Arthritis
- ❑ Asthma
- ❑ Bleeding/Clotting Disorder
- ❑ Cancer
  Where?_____
  When? _____
- ❑ Cataracts
- ❑ Coronary Bypass Graft
- ❑ Dementia
- ❑ Alzheimer's
- ❑ Diabetes/Insulin Dependent
- ❑ Emphysema
- ❑ Glaucoma
- ❑ Hard of Hearing
- ❑ Heart Attack/MI
- ❑ Heart Valve Prosthesis
- ❑ Hypertension/High BP
- ❑ Hypoglycemia
- ❑ Kidney Disease
  Dialysis? Yes__ No__
- ❑ Leukemia
- ❑ Pacemaker
  # _____
- ❑ Seizure Disorder
- ❑ Sickle Cell Anemia
- ❑ Stroke
  When? _____
- ❑ Ulcer
- ❑ Vision Impaired
- ❑ Other: _____

_____

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_____

Type	**RECENT SURGERY:**	Date

ALLERGIES:

OTHER INFORMATION	
Medical Insurance Co.:	
Policy #:	Phone # ( )
Medicare #:	Medicaid #:
Living Will/Advanced Directives on file at:	
Health Care Power of Attorney:	
Name:	Phone #: ( )